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December 7, 2012

Serious Adverse Impact on Amputee Care Would Ensue If Recent Communications from the Center for American Progress Were Adopted, and Competitive Bidding Were Adopted for Acquisition of All Medicare Medical Devices in DMEPOS.

Custom-Fabricated Prosthetics, As Well As Custom-Fabricated and Custom-Fitted Orthotic Bracing Typically Refers to a combination of services for the Medicare Beneficiary which includes both the product and a Long-Standing Clinical Relationship of Patient Care and Clinical Visits/Interactions Between the Medicare Beneficiary Amputee or Limb-Impaired Patient and His/Her Caregiver Where the clinical services needed by the Medicare Beneficiary Amputee or Limb-Impaired Patient.

Dear Member of Congress:

We are writing because we have been very concerned with overly simplistic and under-informed communications which have recently appeared in the name of the Center for America Progress. CAP essentially has argued for universal competitive bidding expansion to encompass every medical device made available to beneficiaries in the Medicare program, and offers the promise that doing so would save the government $38 billion. This is a very tantalizing idea put forward in a delicate time when fiscal cliff/sequestration deliberations could trigger quick attention to a promise of such extensive potential savings. Unfortunately, such universal reliance on competitive bidding would result in devastating interruptions and disorientation of the care of Medicare beneficiary amputees, and of similarly situated beneficiaries with limb impairment from chronic conditions like multiple sclerosis, cerebral palsy, scoliosis, spina bifida and others—patients whose mobility is severely threatened and who rely on ongoing prosthetic and orthotic care to maintain their independence. CAP clearly does not understand that prosthetics for an amputee is more than a simple commodity such as a walker or a cane, it is a medical device that is attached to a person's body and use of the prosthetic device involves a great deal of fitting as well as health care intervention by a provider they trust and who understands their needs. This is what will be lost by treating prosthetics and custom orthotics like a cane or a walker.

Care of these Medicare patients is not accomplished by the mere delivery of a medical device—this is a critically important distinction because prosthetics and orthotics are dramatically different from typical items in the durable medical equipment category. Confusion may be engendered by the fact that, for whatever historical reasons, Medicare payment for orthotics and prosthetics has been made on the basis of the device, rather than on the basis of the number or intensity of patient visits and encounters which are associated with fitting the patient for the device and teaching the patient to properly use the device. That said, the complexity of custom-fabricated prosthetics as well as custom-fabricated and custom-fitted orthotics, coupled with the typical

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patient's need for regular, ongoing training, adjustment, modification and refinement underscores the huge risk and detriment to existing patient care that would be perpetrated if the recommendations of CAP were followed and these custom medical and mobility-restoring devices were treated in the same way as an off the shelf commodity such as a walker or a wheel chair.

Suppose that health economists recommended that Medicare could exercise dramatic cost containment if the program started issuing patient visit vouchers to beneficiaries, directing them to secure their medical visits at the offices of physicians who, while unknown to the beneficiaries, had enrolled in a program committing to the lowest 'per visit' cost to Medicare? Congress would almost certainly reject such a concept as inimical to what the average citizen conceives health care encounters with their physician to consist of, and we would agree.

Medicare has already considered the question of adding prosthetics and custom orthotics to the competitive bidding program and has drawn the appropriate conclusion that they are not a good fit for the program. We agree with this conclusion.

If the concept of universal competitive bidding as touted by CAP were adopted as to prosthetic patients because they would receive the product without appropriate custom fitting, gait training and other clinical services needed to make the device useful to them. We cannot blithely expect that these patients can be re-directed into a program which would have their customized limbs and bracing coming to them in box, directed via a Medicare-sanctioned distribution warehouse operation. Artificial limbs are not diabetic test strips or wheel chairs; they are instead custom made devices tailored, fitted, and modified regularly to the patient's unique anatomical and skin features. Commoditization of prosthetics and orthotics would divorce those patients from maintaining their long-standing clinical patient care relationship and visits with their trusted health care professionals—the specific prosthetists and orthotists who understand and have earned the patients' trust over decades of specialized treatment and care.

We cannot be sure how the blanket approach to competitively bid all medical devices espoused by the CAP might impact other beneficiary-provider relationships. But we know that this would be a terribly destructive idea if applied to Medicare orthotic and prosthetic care, and we therefore strongly urge members of Congress to support the current position of Medicare and reject any such concept of commoditizing orthotic and prosthetic care proposed by the CAP, and in doing so, continue to protect their constituents who are Medicare amputees and limb-impaired patients.

Thank you for your interest and concern for Medicare patients with limb loss and limb impairment, and please let us know if we can provide any further information.

Very truly yours,

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